Loudoun Pediatric Associates

Patient(s) Information (Please include all children)

Last name	First Name	Date of Birth	Sex	Race/Ethnicity	Language
Last name	First Name	Date of Birth	Sex	Race/Ethnicity	Language
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Last name	First Name	Date of Birth	Sex	Race/Ethnicity	Language

EMAIL ADDRESS (REQUIRED FOR ACCESS TO PATIENT PORTAL):

Parent/Legal Guardian Information

First and Last Name	Date of Birth	Relation to Patient(s)	Phone No.
Mailing Address	City/State		Zip Code
First and Last Name	Date of Birth	Relation to Patient(s)	Phone No.
Mailing Address	City/State		Zip Code

Contact Method- (Please circle how would you prefer to be contacted) TEXT MESSAGE or PHONE CALL

Primary Insurance Information

Insurance Policy Holder's Name	Policy Holder's Date of Birth	Relationship to Patient(s)
Insurance Company Name	PCP (If Applicable)	
Policy/ID Number	Group Number	Effective Date	Copay

Secondary Insurance Information

Insurance Policy Holder's Name	Policy Holder's Date of Birth	Relationship to Patient(s)
Insurance Company Name	PCP (If Applicable)	
Policy/ID Number	Group Number	Effective Date	Copay

Authorized Persons (Non-Parent/Non-Legal Guardian)

Please list all individuals ages 18 + who you authorize to bring your child(ren) to appointments and consent to treatment

First and Last Name	Relationship to Patient(s)	Phone Number
First and Last Name	Relationship to Patient(s)	Phone Number
First and Last Name	Relationship to Patient(s)	Phone Number

Patient Insurance Authorization

I authorize my insurance benefits to be paid directly to the physician. The financially responsible party listed above is responsible for all unpaid charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third-party payor, health maintenance organization, insurer or other health benefits plan. This consent applies to Loudoun Medical Group, PC (LMG) or any of its affiliates or agents, lenders or any third-party servicer acting for LMG, PC, or any of its affiliates. I agree to promptly pay for services rendered for me or the patient(s) named above. If I fail to meet my financial commitment to LMG and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection fees. I further agree to pay for any missed appointments for which I did not notify the medical office within a reasonable amount of time. I authorize LMG to test my blood for hepatitis and/or AIDS virus, if in their opinion, an employee has suffered an exposure as a result of treatment, as defined by the Occupational Safety and Health Administration.

Signature: _____ Date: _____

HIPPA-Receipt of Notice of Privacy Practices Acknowledgment

Patient Name: _____

I have received a copy of Loudoun Medical Group's Notice of Privacy Practices and understand that the notice describes how my/the patient's medical information may be used and how access to this information may be obtained. I have also been given an opportunity to ask questions about the information provided in the Notice.

Signature: _____

Date: _____

Relationship to Patient: _____

FOR OFFICE USE ONLY

I attempted to obtain the patient's/representative's signature in acknowledgment of this Receipt of Notice of Privacy Practices Acknowledgement but was unable to do so as documented below

Date	Staff Initials	Reason
		Refused to Sign__ Other _____

Loudoun Pediatric Associates

19500 Sandridge Way, Suite 110, Leesburg, VA 20176 Phone: (703) 723-7337

205 East Hirst Road, Suite 302; Purcellville, VA 20132 Phone: (540) 338-7065 24430

Stone Springs Blvd, Suite 115; Dulles, VA 20166 Phone: (703) 957-1247

Patient Responsibilities

1. Please notify us of any changes in your address, phone number or insurance information at the time of the change.
2. Please notify us 3-4 business days before referrals are needed. If your insurance requires a prior authorization for services or medications, please notify us at least 3 business days in advance.
3. Your provider may order tests that are medically necessary. It is your responsibility to contact your insurance company to determine the facilities that participate with your specific insurance plan for labs, x-rays, and other similar tests. Please allow 5 business days to be notified of these results unless your provider tells you otherwise.
4. All appointments (excluding walk-in sick appointments) must be scheduled in advance. If you need to cancel or reschedule an appointment, please call 24 hours before your scheduled appointment. Your child's account will be charged a fee for any physical or consult not canceled with at least 24 hours notice.
   - **30 minute physicals or consults will incur a $100 charge.**
   -1 hour consults will incur a $150 charge.
   -Lactation Consults will incur a $75 charge
   -Sick visits will incur a $50 charge
   SAME DAY SICK VISITS MUST BE CANCELLED WITHIN 2 HOURS OF APPOINTMENT TIME TO AVOID CHARGES
   Please pay your child's bills promptly. If there is a financial hardship, please contact our Accounts Receivable representatives at (703)737-6001. There will be a $35 charge to your child's account for any returned checks.
5. Parents are responsible for being familiar with their insurance plans and covered services. Charges that are deemed by the insurance company to be patient responsibility shall be paid in full. Payment plans are available based on graduated percentages of the total account balance. A missed payment shall result in a $25 service fee to reactivate the payment plan.
6. Copayments are collected at the time of service. We are no longer able to bill patients for their copayments.. If you are unable to pay your child's copayment, you may be asked to reschedule their appointment.
7. Virginia State Code 8.04-41 allows medical practices to charge a fee for copying medical records. A release of medical records form must be completed and signed by a parent/legal guardian and payment of the records charge must be received before records can be released or transferred.
8. To obtain a prescription refill, please first call your pharmacy, which will then contact our office. We require 3 business days to process your refill.
9. We utilize voice greetings in our offices after regular business hours with the number of our after-hours answering service. Please call (703) 257-3932 to speak with the provider on call. Please realize that the provider is available for urgent medical matters only. Loudoun Pediatric Associates directly bills patients **$35** for each phone call. Parents are responsible for making payment to patient accounts promptly.
10. We have walk-in sick appointments available in our Lansdowne and Purcellville offices Mon-Fri from 7:30 am – 8:30 am and in our Stone Springs office Mon- Fri 8:00- 9:00 for established patients only. These visits are not for ER follow-ups or chronic (ongoing) health issues. You may be asked to schedule an appointment to allow for appropriate time to properly discuss these types of matters. We do not have walk-in appointments available on Saturdays or Sundays. (**WALK IN HOURS AND AVAILABILITY SUBJECT TO CHANGE. PLEASE CHECK WWW.LOUDOUNPEDS.COM OR CALL THE OFFICE FOR MOST UP TO DATE HOURS AND AVAILIBILITY**)
11. We follow the Virginia Board of Medicine regulation (18VAC85-20-26) that requires us to maintain patient records for at least 6 years after the last encounter or until a minor child is at least 18 years old with a minimum of 6 years since the last patient encounter. We automatically shred paper charts of non-current patients after meeting this record retention obligation. This regulation concerns patients who visited LPA prior to 2007; we have used electronic medical records since that period.
12. Our prices are set by our parent company, Loudoun Medical Group, and are thus subject to change without notice. We charge you insurance company as a courtesy to you and your family. We charge based on Current Procedural Terminology (CPT) codes. You are welcome to ask for the price of services or medicine before obtaining it at any time; however, you are responsible for all charges billed to your insurance company that your insurance company deems as an "appropriate charge" but then applies as patient responsibility. We cannot be responsible for the insurance coverage chosen by your employer or the policyholder.

I have read and understand the responsibilities above.

Patient Name(s): _____

Parent Signature: _____ Date: _____